Vol. XVII. APRIL, 1878. No. 100.

THE

AMERICAN PRACTITIONER:

A MONTHLY JOURNAL OF

MEDICINE AND SURGERY.

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PUBLISHERS:

JOHN P. MORTON & CO., LOUISVILLE.

E. B. PORTER, INDIANAPOLIS.

THREE DOLLARS PER ANNUM.

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Articles intended for the *Original Department* of this journal must be contributed to it exclusively.

The editors are not responsible for the views of Contributors.

THE AMERICAN PRACTITIONER.

APRIL, 1878.

Certainly it is excellent discipline for an author to feel that he must say all that he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want downright facts at present more than anything else.—RUSKIN.

Original Communications.

PULMONARY CONSUMPTION.*

BY GHISLANI DURANT, M. D., PH. D.

Member of the American Medical Association, Member of the Medical Society of the County of New York, Fellow of the New York Academy of Medicine, Etc.

SCROFULOUS PHTHISIS.

Scrofula, which we may look upon as a sort of connecting link between suppuration and tuberculization, is a most fruitful source of inflammation, of purulent products, and of pyemic conditions. The first description of scrofulous phthisis dates back to Morton. Succeeding observers have almost, without exception, grossly exaggerated or entirely denied his conclusions. Thus, on the one hand, Laënnec and his school do not admit the existence of scrofulous phthisis; while, on the other hand, Sauvages† and Portal‡ make all hereditary phthisis depend upon a strumous affection. Some observers go

* Continued from March No., p. 168.

† Sauvages. Nostalgie, tome ii, pp. 272 and 409.

‡ Portal. Nature et Traitement de la Phthisie Pulmon., p. 43. Bidlot, p. 110.

further still. According to Bayle,* every phthisis is scrofulous in its nature; Graves† is of the same opinion; while Lugol‡ would have scrofula to be one of the modifications, or rather one of the symptoms, of phthisis. Scrofula, according to Broussais,§ is only a local alteration, due to irritation and inflammation of white tissue, developed under the influence of the lymphatic temperament.

"Long since," says Virchow,‖ "I demonstrated the analogy existing between alterations taking place in the lymphatics in the scrofulous tuberculous diathesis, and in typhoid."

Bazin** describes the stages of scrofula as, first, hypertrophy; second, adenitis or inflammatory engorgement; and third, tuberculous infiltration.

Villemin†† regards caseous degeneration as a local lesion, which, in the great majority of cases, follows pathological changes occurring in tissues where the lymphatic radicles of the diseased ganglia are distributed.

Guersand‡‡ says that "scrofulous adenitis must henceforth be considered as a form of general tuberculosis."

Tubercles of scrofulous origin usually present certain characteristics, which may enable us to recognize them. Very often they are found in one lung only; they are large, and exist in compact masses. They have a great tendency to undergo complete fatty degeneration, so that it is not at all rare to find them having a decidedly fatty look; even those that soften first undergo a far greater fatty degeneration than tubercles of other forms of phthisis. They remain a long time before softening begins, and this process progresses very slowly.

The portions of the lung surrounding the tubercles are

* Bayle. Recherches sur la Phthis. Pulmon., p. 76. Paris, 1810.

† Graves. Clinical Lectures, ed. by Neligan.

‡ Lugol. Recherches sur les Maladies des Scrof. 1844.

§ Broussais. Traité des Phlegmasies Chroniques, tome ii.

‖ Virchow. La Syphilis Constitutionnelle, trad. Picard, p. 16.

** Bazin. Leçons sur la Scrofule.

†† Villemin. Etudes sur la Tuberculose, p. 204. Paris, 1868.

‡‡ Guersand. Article, Scrofule. Dict. de Médecine.

sometimes the seat of a gelatinous exudation. According to Niemeyer, under such a condition, there will be found at the outset, especially at the surface, or on the borders of the lung, or in the parenchyma, near the miliary tubercles, isolated lobules, transformed into gray or reddish-gray homogeneous masses. A few whitish or yellowish points then make their appearance, and go on developing until the whole presents a uniform yellow, smooth and dry appearance. Imbibition by the tissues of the lung, their destruction, and the formation of irregular cavities, with jagged edges, soon follow, and all the symptoms of phthisis are manifest. This form, on account of its superficial seat, often attacks the pleura, producing pneumothorax.

Bazin also has shown that scrofulous tubercle is sometimes deposited, in more or less considerable masses, on the internal face, and sometimes even upon the external face, of the pleura.

In scrofulous, as in other forms of phthisis, the softening of the tuberculous deposit leads to the formation of cavities, while ulcerations in the larynx, trachea or intestines, are rarely met with in this form of the disease; their occurrence in the lymphatic, cervical and mesenteric glands, the result of infiltration, is quite common.

Abscess of the lung, according to Bazin, must be connected with scrofulous phthisis, since it is not only found coëxisting with pulmonary tubercles, but when isolated its symptomatology coincides with that of phthisis. Sometimes these purulent collections present all the characteristics of a deep metastatic abscess, and are found in the middle of the pulmonary parenchyma; but more often the cysts are situated immediately under the pleura, or between the lobes of the lung.

Like all the accidental forms, the scrofulous may, after a time, become complicated with the essential phthisis, through the development of neoplastic tubercle.

One of the characteristic consequences of the scrofulous diathesis is the predisposition to chronic inflammatory affections of the skin and mucous membranes. A glance at a scrofulous person is sufficient to recognize the affection: the

thick, cracked lips; the yellow, dirty, carious teeth; the fungous gums; the foul breath,—all tell of a diseased mucous membrane; while his bleared eyes, his large, scabby nose, his constant snuffling, indicate the existence of a constitutional vice. Add to the above coryza, bronchitis, diarrhœa, disease of the skin and ulcers, and you have before you the sad lot of the scrofulous individual. His phthisis is only the effect of his predisposition to chronic inflammatory affections.

It is but rarely that hemoptysis occurs at the onset of scrofulous phthisis; and its occurrence would lead to a very strong suspicion of the presence of essential phthisis as a complication, though, in the latter stages of the disease, hemorrhages, resulting from the ulceration of a blood-vessel, are quite common.

The softening of the tubercles is announced rather by physical signs than by an aggravation of the symptoms. There is little or no hectic fever; cough and purulent expectoration, especially in the morning, is present; the patient's appetite remains fair; his face is full or rather bloated, and the cheeks present a circumscribed redness, while the embonpoint remains. "It is curious," says Bazin,* "to see individuals, in whom we recognize, by percussion and auscultation, vast caverns in the subclavian regions, apparently enjoying all the attributes of perfect health, going into society, and attending to their usual occupations, as if they were not sick."

Hence when, in a manifestly scrofulous subject, we find the general symptoms of phthisis; when these symptoms have followed a bronchitis or a pulmonary inflammation, whose progress has been slow; when hemoptysis has been absent at the outset of the disease; when there is but little or no hectic fever; and, finally, when the preservation of the strength, appetite and embonpoint, form a strong contrast to the grave lesions revealed by a physical examination of the lungs, we may diagnose with certainty scrofulous phthisis.

The general treatment of scrofula in youth, the treatment

* Bazin, loc. cit., p. 465.

which of all gives the best results, is sea-bathing.* We must watch carefully for any catarrhal or inflammatory affection of the pulmonary organs in those who are scrofulous. In such a case, besides expectorants, we have need of antiscrofulous treatment. None will equal mercury. (Graves, p. 526.) We must next endeavor to improve the general nutrition, by attention to the quality and quantity of the food, by enjoining residence in a healthy climate, by ordering exercise in the open air, by taking care that the patient never sits or sleeps in a vitiated atmosphere, and by advising warm clothing.

Among medicaments, unless contraindicated by digestive weakness, we give cod-liver oil—the best is Moller's. For the heavy, bloated patient, iodine and the iodides and bitters. Bazin highly extols the tincture arum triphyllum. When not contraindicated, the hypophosphites, leaving off their use if they produce excitement of the genital organs. Trousseau recommends that a large hemlock plaster be applied to the chest. A favorite and fashionable mode of treatment consists in the use of mineral waters. Those containing sulphur, iodine, bromine or arsenic, should be selected. The grape-and-milk cure have, for the past few years, been spoken very highly of in Europe.

Much attention should be given to the diet, which must be at once tonic and reparative. Nutritious, easily-digested food, tonics, quinia, wine in moderate quantities, should be ordered; while vegetables generally, food rich in starch, and sweets, should be forbidden.

SYPHILITIC PHTHISIS.

The physicians of the last century described, under the name of *phthisis a lue venera*, a pulmonary affection caused by the venereal virus, and differing from that special state we call cachexia, without, however, giving its anatomical lesions.

Many authors have written upon the connection between syphilis and tubercle. Morgagni regarded it as merely a pre-

* Brochard; des Bains de mer chez les Enfants. Paris, 1864.
G. Durant; Sea-Bathing—its Uses and Abuses. Cogswell. New York, 1877.

disposing cause of ordinary phthisis. Laënnec and Andral consider syphilis as favoring the development of tubercle, by the state of marasmus it produces; Beaumes thinks that the phthisis is due to a special morbid perversion of the nutrition of the lung by the venereal poison; while Bayle and Portal speak of a morbid excitation of the lungs from the same cause. It is only within the last few decades that the existence of a special form of phthisis, due to syphilis, has been established, and to this the name of syphilitic phthisis given.*

Without dwelling upon the facts gleaned from medical works, upon which the two theories of the action of syphilis are founded, we may briefly state the two doctrines:

1st. Certain pulmonary diseases are produced directly by syphilis.

2d. Syphilis is a simple occasional cause of these diseases.†

Syphilis, during the eruptive stage, especially in young women, may give rise to symptoms indicating the development of phthisis. Cases may be cited from the practice of Von Ziemssen,‡ Lancereaux and Frey,§ in which deposits in the lung accompanied by hectic fever, in persons suffering from syphilis, yielded promptly to mercurial treatment.

Syphilis can also cause destruction of the lungs, either through the injury done the general health, or from the matter from laryngeal ulcers being carried into those organs.

Grandidier‖ states that among several hundred cases of constitutional syphilis, he has treated thirty with lung diseases, which he believed to be syphilitic, on account of the history, physical changes, and success of treatment. All the patients were adults. The right middle lobe, near its base, was most often involved; the left lung very rarely. There were signs of

* Baümber. Art. Syphilis, Cyclopædia of the Practice of Medicine, Vol. III, p. 211. New York, 1875.

† Lancereaux. Traité Historique et Pratique de la Syph., p. 324. Paris, 1874.

‡ Ziemssen's Cyclopædia of the Practice of Medicine. Translation. William Wood and Co. New York, 1875.

§ Allgemeine Medicinische Central-Zeitung. Berlin, June 28, 1876. Stuck. No. 52.

‖ Archives of Dermatology, Vol. II, No. 11, p. 180. New York, 1876.

consolidation, sometimes of a cavity; the lower lobe always remaining normal. The author believes the localization of the disease upon the right middle lobe to be pathognomonic, while at the same time it is diagnostic of the absence of cheesy pneumonia, in which the apices are most prone to suffer. Of Grandidier's thirty cases, the right middle lobe was involved in twenty-seven, the apex of the right lung in two, and the left lung in one case only. He names Michaelis* as a supporter of his view, that in syphilitic phthisis the apex of the lung is seldom involved.

Jos. Franck† has described as syphilitic phthisis, a chronic bronchial or pulmonary affection caused by syphilis.

Führer‡ says that in the adult there is found a special form of pneumonia, the result of syphilis, in which there is a simultaneous though distinct onset of a diffused infiltration of the lung, and a lobular bronchial exudation.

Dietrich§ has described grayish cicatrices, formed of hard tissue, in the lower lobe of the lung of a syphilitic.

Ricord states that "for several years we have had, in a number of autopsies, large enough to enable us to form an opinion, pulmonary lesions which must, of necessity, have had their origin in syphilitic tubercle."

According to Virchow,‖ all gummata originate in a proliferation of the connective tissue; and the beginning of their development is similar to that in the formation of granulations.

It is but very recently that the circumscribed or gummy pneumonia, pointed out by Morton,** Astruc and Fabie, has really been studied; and even now we must admit that our knowledge of it is very imperfect. The few facts recorded show that these growths are deposited any where in the lung, with a tendency, when they occupy the superior lobe, toward the middle and lower portion, rather than the apex.

* Comp. der Lehre von der Syph., 1865, p. 126.

† Quoted by Bidlot. Phthisie Pulmonaire, p. 131.

‡ Quoted by Virchow. Syphilis Constitutionnelle, trad. Picard, 1860, p. 155.

§ Quoted by Bidlot, p. 134.

‖ Virchow. Syphilis Constitutionnelle, p. 675.

** Morton. Phthisiologie, p. 107.

These neoplasms exist in variable numbers; sometimes they are single, more often multiple; but their number rarely exceeds six or eight. The gummy tumor, though essentially the product of a dry inflammation, soon undergoes the granulo-fatty metamorphosis; and, from a hard, elastic body, it becomes a caseous mass, the changes beginning at the center and extending to the circumference. At this period the neoplasm may, in part or entirely, be absorbed; usually, however, it is expelled through the bronchi, leaving a cavity, varying in size, lined by a caseous deposit, and enclosed by a membraneous wall, of more or less dense fibrous tissue.

By what means the contents of this cyst are evacuated is not known, but there is every reason to believe that it does not differ from that which takes place in the case of subcutaneous cellular gummata—ulcerative inflammation. The ulcers in the lungs, like those of the tissues just mentioned, may heal and leave cicatrices. These were, for a long time, supposed to be due to tuberculosis alone; but there is every reason to think that the traces of different diseases have often been confounded.

A very careful examination is necessary to determine whether the phthisis be of syphilitic origin or not. Diffused chronic pneumonia is usually circumscribed, rarely attacking an entire lobe; the resulting neoplasm contains within thick walls a yellowish substance, more or less striped, and differing slightly from the hard, brilliant, marbled substance, the result of an ordinary chronic pneumonia. The gummata in syphilitic phthisis are the result of a dry inflammation, are slightly vascular, and surrounded by a fibrous zone, which is very thick (p. 324).

Yvasen,* while denying that syphilis can produce tubercle, admits that it may borrow the various symptoms which characterize the presence of tubercle, such as hectic fever, emaciation, incessant cough, and shortness of breath.

The differential signs are, absence of fever, exacerbation of pain during the night, and a breath so fetid that once recog-

* Yvasen. Des Métamorphoses de la Syphilis, p. 345. Paris, 1854.

nized it can not afterwards be overlooked. The feeling of oppression in syphilitic phthisis is referred to the larynx; in tuberculosis, to the chest. "What if in a patient with a more or less complete aphonia; tormented by an incessant cough, and a constant and extreme sensation of suffocation; reduced by insomnia to a great degree of emaciation; to these be added the absence of tubercular deposit in the lungs, or at least the presence of such a deposit in a degree not at all sufficient to account for the general state; a thready, mucous expectoration, very rarely puriform, and always differing from the striated, rounded, mummular expectoration, containing portions of white opaque matter, resembling boiled rice, the characteristic sputa of tuberculosis; if there be no true hemoptysis, and the antiphlogistics, the calmants, etc., are powerless, I say that I have a right to suspect that the disease is specific." "My belief would become complete, and my diagnosis beyond cavil, if a careful examination revealed, with the simulated signs of tuberculous phthisis, the coëxistence of symptoms of syphilis, such as a papulous, tuberculous or pustulous eruption, a rebellious purulent ozena, gummata, exostoses, caries, pains in the bones at night, or aggravated during the night; then in nearly every case the mask falls, the phthisis tuberculosis disappears, and the syphilitic affection remains."

The physical signs, of the presence of gummy tumors in the lung, become more evident after the softening has taken place; then the examination gives the signs which accompany any excavation of the lung tissue.

There are no true pathognomonic signs of syphilitic phthisis; its diagnosis must rest chiefly upon the antecedent history of the patient, and the nature of the concomitant affections. Certain peculiarities of the pulmonary disorder may, however, aid us in determining whether it be of syphilitic origin or not. Tuberculous phthisis differs from it in its more rapid development, the greater extent of lung involved, and its beginning being commonly at the apices of the lungs.

The prognosis in syphilitic phthisis is always grave, not so

much on account of the pulmonary lesions, as on account of the alterations which take place at the same time, and from the same cause, in the other viscera. Although a cure is often possible, we must never forget that these affections of the lungs never show themselves until an advanced stage of the syphilitic disease, and therefore when the organism has already undergone a grave modification.

The basis of treatment of this form of phthisis consists, of course, in the employment of medicines which destroy the special virus. We would err, however, if we employed these alone. Cod-liver oil, expectorants, calmants, bitters, tonics, and quinia, all aid and should be used with the specific medication, which includes mercury, potassium iodidi, and sudorifics. Potassium iodidi has been used with much success, especially in those cases where the patient had undergone a mercurial treatment.

HYDATID PHTHISIS.

The presence of hydatids in the lung produces so rapidly so great a state of weakness in the system, that several authors characterize this state as hydatid phthisis, thus expressing, in a forcible and brief way, the grave pathological changes impressed upon the organism by the presence of these cysts.

This is a purely accidental lesion. The parasite enters by chance the organism, and is left in some organ, where its presence is made known by local disturbances and physical signs; the constitutional disturbance being only consecutive to the loss partly or completely of the organ, and the suppression of an indispensable function.

When bronchitis or pneumonia, caused by the presence of these parasites, becomes chronic, there is found very often tuberculous matter, by the caseous degeneration of the cysts, which have developed in the respiratory organs, and of the exudation consequent upon the irritation their presence produces.

Jenner was the first to demonstrate the hydatid origin of phthisis, by showing that phthisis in the cow was sometimes

the result of the presence of this parasite. About the same time, a learned French veterinary surgeon (Dupuy*), also pointed out the connection between the presence of hydatids in the lungs of the cow, and the development of phthisis in the animal; and thought that light might be thrown upon the origin and formation of tubercle, from a careful study of these cysts. In 1825, John Baron,† an English physician, attempted to prove that tubercles were only hydatids in a state of degeneration—an opinion held later on by Drs. Leveillé and Tigri.‡ In 1832, Dr. Kühn, of Niederbronn,§ discovered the part which hydatids take in the production of tubercle, and although he is generally accredited with the opinion that the latter is caused by hydatids, Bidlot tells us that his belief is just the opposite.

Dr. Hearn,‖ in a very interesting work, has collected many facts, showing the importance of bearing in mind that such a form of phthisis, though rare, does exist, and is often mistaken for essential phthisis, until a careful microscopic examination of the expectoration shows the true nature of the disease, in which the characteristic signs of true phthisis—the cough, the expectoration, the hemoptysis, the night-sweats, and hectic—are all present. Dr. Hearn makes two varieties of hydatid phthisis:—first, that in which the onset is slow, and which is the usual form; and, second, where the attack is sudden and violent, the exceptional form.

The symptoms attending the presence of hydatids, in the pulmonary tissues, are of two classes, namely,—first, local; and second, general:

General Symptoms.

1. A dry, spasmodic, paroxysmal cough, which, later on, is accompanied by an expectoration of a variable nature.

* Dupuy. De l'Affection Tuberculeuse Vulgairement Appelée Morve. Paris, 1817.

† Baron. Observations on Tuberculous Diseases.

‡ Revue Medicale Française et Étrangère, Avril, 1850. Bidlot, p. 156.

§ Kühn. Recherches, etc. Strasbourg, 1822.

‖ Hearn. Kystes Hydatiques du Poumon et de la Plèvre. Paris, 1875.

Should one of the cysts be ruptured, the cough becomes so violent that fear of immediate suffocation may well be entertained. Relief is usually obtained on the escape of a quantity of fluid from the mouth. This fluid is almost characteristic—clear, watery, and salty to the taste; it almost always furnishes to the careful observer sufficient grounds for a diagnosis.

2. Dyspnœa, whose intensity is dependent upon the size and position of the cyst or cysts.

3. Hemoptysis. Previous to the rupture of a cyst, the hemorrhage is very slight—rather an oozing of blood sufficient to stain the expectoration than a true hemorrhage. But, following the rupture of a cyst, and the expulsion of its contents, the hemorrhage is so great that suffocation almost follows. The hemorrhages are very sudden in their onset.

4. Pain in the afflicted side, with a sensation of the presence of a foreign body.

5. Loss of strength, out of all proportion to the appearance presented by the patient. The fever and night-sweats are very slight.

Local Symptoms.

1. A globular tumor of the thoracic walls, due to the presence of the cyst.

2. Diminution or total loss of the power of transmitting the sound of the voice to the thoracic walls.

3. Dullness on percussion, when the cyst is in contact with the thoracic walls, the limits of which mark the outlines.

4. In certain situations of the cyst, absence or diminution of the respiratory murmurs, and puerile or bronchial breathing in its vicinity. Egophony very rare.

5. The expectoration is characteristic, and is either a clear fluid and transparent, or contains membranes.

But little can be done in the way of medication. Mercury, on account of its parasiticidal properties, has been used. Beaumes relates cases where the mercurous chloride has been successful. Laënnec advises the use of sodium chloride. Bird, although doubting the efficacy of medication, thinks that po-

tassium bromide may destroy the hydatids. He advises also the use of kamala, which had been employed by Hjaltelin, of Iceland. It has been proposed to use iodine, camphor, santonin, in the form of spray, in order to reach directly the seat of disease. The surgical treatment consists in incisions, punctures, and the use of the continued current.

DIABETIC PHTHISIS.

Impressed by the gravity of the pulmonary lesions occurring during diabetes, and their extremely rapid development, several authors have been led to regard this disease as a cause of phthisis.

Diabetes was known to the ancients, as the descriptions of Celsius, Aretius and Paulus Egineta show, though our first real knowledge of its nature begins with the investigations of Willis, an English physician of the seventeenth century, who was the first to demonstrate the presence of sugar in the urine. The best work (with which I am acquainted) on this subject, is that of Dr. Bertail,* to whom I am indebted for the material immediately following:

Morton pointed out that a relation existed between diabetes and pulmonary phthisis (*de tabe a diabete*), and Rollo,† that in the sufferers from diabetes pulmonary symptoms existed. Reguoso,‡ believing that glycosuria was caused by impairment of respiration, made phthisis the cause of diabetes. Bouchardat§ says that in nineteen cases of deaths from diabetes, he found in every one tubercles in the lungs; while Griesinger,‖ in 1859, stated that the result of his investigations showed that tubercles were present in forty four per cent. of the cases examined. Pavy** believed that the phthisis occurring during diabetes, is due to a chronic inflammation

* Bertail, (Er.) Etude sur la Phthisie Diabétique. 1873.
† Rollo, (John). Trad. par Alyon. Paris; An. VI.
‡ Compendium de Médecine Pratique, p. 35, 1839.
§ Bouchardat. Annuaire de Thérapeutique, 1841 à 1869.
‖ Von Griesinger. Studien über Diabetes. Bertail, p. 15.
** Researches on the Nature and Treatment of Diabetes. 1862.

of the pulmonary parenchyma. Pidoux,* in his prize essay, devotes many pages to this subject; as do Durand-Fardel,† and Marshal de Calvi.‡

Pulmonary phthisis only occurs in very severe cases of diabetes; and, according to Bouchardat, it is necessary that the diabetes should have existed for a certain time, and a large amount of sugar—one hundred grammes—be passed; otherwise tuberculosis is not produced. If, however, the course of the diabetes be not arrested, or its severity modified, then, notwithstanding the previous condition of the individual may have been ever so favorable, one-third of the cases at least would develop and die from tuberculosis.

During the interval between the appearance of the glycosuria and the manifestation of pulmonary trouble, a period always more or less long, the patient has been greatly weakened and reduced in flesh by the constant drain due to the former disease; and even at the beginning of the pulmonary trouble, the general health is most seriously impaired.

The time at which phthisis is developed in a diabetic patient is dependent upon two sets of influences—the first, due to his hygienic condition and surroundings; and second, to causes inherent in the subject himself. Among the latter may be mentioned age, sex and constitution.

Diabetes is very rare in both infancy and old age, and is, therefore, at those epochs, seldom met with as a complication or cause of phthisis.

Diabetic phthisis, in the greater number of cases, runs a very rapid course; and most writers speak of caverns and other lesions of the lung, identical with those found in ordinary tuberculosis. In fact, the only characteristic at all distinctive of this form of consumption, is the rapidity of its development. It would be an error, however, were we to regard all the excavations found in the lungs as caused by tubercles. Pulmonary gangrene is quite frequent in diabetes, and as it does not present the fetor usually distinguishing it, a

* Loco citato, p. 309.

† Traité Clinique et Thérapeutique du Diabète. 1869.

‡ Des Accidents Diabétiques. Paris, 1864.

very careful examination is requisite, or this condition will be overlooked.

Pulmonary diabetic phthisis is so insidious in its attack, that it is almost impossible to fix, with any degree of certainty, upon the precise time at which it began. The patient has been losing flesh; his digestion is disturbed; gastralgia, increased after the ingestion of aliments, appears; nausea, eructations and vomiting follow, and the relation which should exist between the ingesta and egesta is broken. Respiratory disturbance, at first slight, increases rapidly, until the difficulty in breathing is out of all proportion to the other symptoms. The cough, at the beginning of the pulmonary trouble, is short, frequent, and often there is no expectoration; with the formation of cavities, however, expectoration begins, and toward the latter stages of the disease often becomes very abundant, and presents all the characters of the sputa of ordinary phthisis; night-sweats rarely occur; the skin is hot, dry, roughened and scabby, feeling somewhat like parchment. The temperature of the body—and this is almost peculiar to diabetic phthisis—is lowered. Hemoptysis is an exceptional occurrence.

Later on, as the phthisical lesions increase, that which before was a complication or outgrowth of the glycosuria, becomes the leading disease; and, judging from the prominent symptoms, the case might be mistaken for an ordinary phthisis.

In the beginning, the treatment of this form of phthisis must be directed almost exclusively against the cause of the disease—the diabetes. A carefully selected diet, all sugar-forming substances being excluded, and the use of Vichy waters, bitters, a solution of ammonium carbonate with rum, extract nucis vomicæ, in from one-half to three grain doses, strychnia, in doses of from one-twentieth to one-tenth of a grain, give excellent results, by correcting some of the digestive disorders. Calcium sulphide has, in several cases, stopped all elimination of sugar in the urine. The patient should be kept warm; the tendency should be toward too great an amount of clothing.

If the diabetic phthisis has become established, then we must follow the treatment appropriate to ordinary phthisis, always remembering, however, that sugar-forming articles are to be strictly prohibited, and the diet wholly animal. With a nitrogenized diet, and a moderate amount of exercise, we may hope yet to diminish the intensity of the diabetes. If, however, tubercles have already been developed, we have but little chance of hindering the progress of the disease.

Cod-liver oil, as it is a hydro-carbon, may advantageously replace all farinaceous food. For the cough, opium and revulsives, (blisters, croton oil, etc.,) applied over the apices of the lungs, may be used with advantage.

NEW YORK CITY. (To be continued.)

TYPHO-MALARIAL FEVER.

BY T. B. GREENLEY, M. D.

As far as I have observed, there has but little been published in the medical periodicals on the subject of typho-malarial fever. Indeed, Dr. Flint gives but little space to its consideration in his systematic work on practice. I think it is comparatively a new disease in our country.

I do not recollect having seen a case of it anterior to the fall of 1875, when some six cases came under my observation, all being in the same family. This family resided some fifteen miles distant in Bullitt county, and was under the medical care of my friend, Dr. Johnson, now of Pitt's Point.

I was called to see Mrs. C. in consultation on the 25th of September. She had been sick some ten days or two weeks, and her medical attendant had treated her in the usual way for remittent fever, without producing any favorable impression on the disease. She had some of the symptoms belonging to typhoid fever, and some belonging to malarial fever. There

were present some tympanitis, nervousness, incoherency in talking when partially asleep, sordes, and red-edged tongue. Of the malarial symptoms, she had nausea, exacerbations of pain, headache and flabby tongue. As Dr. Johnson had fully exhausted the virtues of quinia as an abortive of simple malarial fever, I advised simply an expectant treatment—only giving her a small powder of quinia and Dover's three times a day; also, should her bowels bear it, ten grains of the hyposulphite of soda in solution, as a febrifuge and alterative.

I saw no more of this patient until the 9th of October, when I was called to see the husband and eldest son and daughter, affected with the same character of disease. The wife or first patient was now about clear of fever, with some appetite, and in a short time became convalescent. The husband seemed to be more impressed with the typhoid element than had been the wife—more delirium, and a greater tendency to diarrhœa. The daughter was also more nervous than her mother had been. Before these latter three patients recovered, the second daughter and son were taken sick with the same disease, and ran very much the same course.

It was only occasionally that I had an opportunity of visiting these patients, and could not in consequence keep anything like a satisfactory record of the symptoms during the progress of the disease; and I believe that my friend, Dr. J., did not make notes of the cases. They all, as far as I observed, partook of the characteristics both of typhoid and malarial fevers; and all had the advantage of a free trial of quinia in the outset, without any apparent beneficial results. These six cases recovered, and have enjoyed good health ever since. In fact the eldest daughter, who was apparently the worst, and who was naturally quite delicate, has had better health than previously.

I saw no more of this disease until the 29th of July, 1876, when I was called in consultation with my friend and neighbor, Dr. Foss, to see Miss A., who had been sick some two weeks. She had, besides the ordinary symptoms of this disease, an eruption, very similar in appearance to varioloid, so

much so in fact as to impress Dr. F. with the necessity of using precautionary measures to prevent its spreading among the neighbors. Not having seen a case of the disease under consideration accompanied with an eruption similar, I was at first undecided as to whether it was varioloid; but on close inspection, I found that some of the sores had healed without pitting, others fully maturated, and yet others in the forming stage. This condition convinced me that the case was not one of varioloid, as the whole crop of eruption in that disease makes its appearance about the same time. We put her on quinia and Dover's powder three times a day, with hyposulphite of soda in solution. She was in bed about six weeks and recovered.

I saw some four or five cases more during the summer and fall of this year, all of which ran about the same course, the same treatment being pursued, and all recovering. During the summer and fall of 1877, I saw some five or six cases, but only kept notes of two, which I considered as typical of the disease, only being more mild in some of the symptoms.

Mr. R., a young man of about twenty years of age, and naturally stout and healthy, had been sick a week when I was called to see him on 20th of October. He had complained of lassitude, headache and some fever. When I saw him his temperature was 104, while his pulse was only 60; respiration natural; tongue red at edges, but large, flabby, and covered with moist coat; bowels regular, and no tenderness; urine high-colored; intellect rather dull, but no delirium; some subsultus, but no jactitation or borborygmus. Although I was confident of the typhoid character of the case, I gave him the trial of free doses of quinia as in true remittent, but it did not reduce his temperature, or in the least modify any of the symptoms, as far as I could perceive. After giving him quinia in full doses, at short intervals, until I saw no good result, I then commenced my ordinary treatment of medium doses of quinia and Dover's powder, together with the hyposulphite of soda in solution, three times a day. Diet, milk and soups of different kinds; no solid food.

On the 23d, his temperature and pulse were the same as when I saw him on the 20th, although he had taken eight grains of quinia, five grains of Dover's powder, and ten grains of hyposulphite of soda, at intervals of four hours; the other symptoms about the same.

Oct. 26th. Temperature 102, pulse 60, other symptoms the same, except a tendency to diarrhœa. On this account suspended use of the hyposulphite of soda; besides he perspired freely at night.

Oct. 30th. Temp. 103, pulse 60, other symptoms about the same, except more incoherency; bowels checked, and hyposulphite of soda renewed, as his temperature had increased.

Nov. 5th. Temperature and pulse same, as well as other symptoms.

Nov. 8th. Temp. 102 and pulse 60; other symptoms same; same treatment continued.

Nov. 11th. Temp. 100 and pulse 50; all other symptoms modified; some appetite; treatment continued.

Nov. 14th. Temp. 98½, pulse 50; quite cheerful, and improving in every respect, in fact dismissed as convalescent.

The most singular symptom in this case was the infrequency of the pulse. Notwithstanding his temperature for several days stood at 104, his pulse never exceeded sixty per minute. His respiration stood at eighteen to twenty during his sickness. I have examined his pulse since his recovery, and find its natural frequency is sixty.

The other case of which I took notes was Mrs. V., a lady of about twenty years of age, naturally healthy. I saw her, the first time, on the 24th of October; had been sick a week; temperature 103, pulse 100, and respiration 20; tongue large, flabby, and red at the edges, with thin coating; intellect clear, some nervousness, slight subsultus, and jactitation; slight tympanitis, but no tenderness, except at the precordia; bowels torpid, urine somewhat scanty and high-colored. Tried her on quinia in full doses, with Dover's powder and hyposulphite of soda, for three days, without modifying the fever. Diet, milk and soup at regular intervals.

Oct. 28th. Temperature 104, pulse 96, and other symptoms about the same; changed treatment to five grains of quinia and five grains of Dover's powder three times a day, with ten grains of hyposulphite of soda at same intervals.

Oct. 31st. Temp. 103½, pulse 90, other symptoms about the same; treatment continued.

Nov. 5th. Temp. 103⅙, pulse 88, other symptoms about the same; same treatment.

Nov. 10th. Temp. 101⅗, pulse 96; other symptoms same.

Nov. 14th. Temp. 100⅜, pulse 80; general improvement in other symptoms; appetite better; treatment and diet same.

Nov. 18th. Temp. 98, pulse 72; convalescent.

Remarks.—I have within the last three years seen, in consultation and my own cases, seventeen patients with what we term typho-malarial fever, all of whom recovered. The first cases I saw in 1875, not knowing anything of such a disease, I looked upon as being dangerous, and was doubtful of their recovery; but as they, as well as those seen in 1876 and 1877, all recovered, I am inclined to think most of such cases occurring in our section of country can be treated successfully.

The disease in its incipiency has some of the characteristics, in many instances, of pure typhoid fever. The patient may complain, several days before confinement to bed, of general lassitude, loss of appetite, headache, with some fever, etc., but is in some cases more sudden in its onset, being very much like a case of true remittent. Therefore, it is a practice with me in all cases to give the patient the benefit of free doses of quinia, at short intervals, for forty-eight or seventy-two hours, so that if my judgment should be wrong in mistaking a case of simple remittent for one of typho-malarial trouble, the quinia treatment will correct the error. The reasons why I continue quinia in smaller doses at longer intervals, after I am convinced of the true character of the disease, are, in the first place, I believe that malaria is one of the factors playing a conspicuous part in the production of the trouble; and, secondly, I conceive it to be adapted to the treatment on

general principles, especially when combined with the other remedies. Our object in the treatment of typhoid fever is the gradual reduction of temperature, as well as to combat untoward symptoms and complications as they may arise. Hence we use medicines possessing febrifugal properties; and here the question arises, have we any better, and at the same time safer, than those of quinia and hyposulphite of soda? The Dover's powder, in conjunction with these remedies, exerts a soothing and quiescent effect on the nervous system, which seems to me to clearly indicate its use. There are some instances wherein the hyposulphite of soda is contra-indicated. These are where there is a tendency to diarrhœa, as that medicine has a slight laxative effect. But it is a habit with me to administer the hyposulphite of soda whenever it is not contra-indicated on account of diarrhœa, not only in this disease, but also in common remittent fever, believing it to exert not only a febrifugal effect, but also an alterative or antimalarious effect.

As to diet, it is my custom in this disease, as in true typhoid fever, to confine my patients on fluids, given at regular intervals—milk being the principal article; different kinds of soup or broth also being allowed as a change, with a little thickening, especially when convalescence sets in.

As to the true character of what is termed typho-malarial fever, there seems to be some controversy, both as to its cause and pathology. Surgeon Woodward, United States Army, is of the opinion that it partakes both of the nature of typhoid fever and remittent, and has for its factors the causes of both of these diseases. This view on his part seems to have been early taken, and apparently was corroborated by a great many army surgeons during the late civil war.

On the other hand, Assistant Surgeon Smart, United States Army, in a very able and interesting article on "Mountain Fever and Malarious Waters," in the January number of the American Journal of Medical Sciences for 1878, controverts this view in a very ingenious and apparently successful manner; but in order to do so, has to build up rather a new theory

in regard to malaria. The surgeon made most of his observations at Fort Bridger, in Wyoming territory, where he was stationed from August, 1873, to July, 1876. This locality is seven thousand feet above the sea level, and *a priori* should be free from malarial affections; but it seems what is called mountain fever, or what we call typho-malarial fever, is prevalent at that high altitude.

The investigating mind of Surgeon Smart induced him to analyze the water of Black's Fork, whence the troops received their water supply. He found a large amount of vegetable débris, and accounted for its presence by the action of the winds, gathering it from distant plains and valleys where malaria is generated in quantities, and carried up to the mountainous highlands and deposited, both by rains and snows in those regions. He ingeniously argues that if our established notions of imbibition of malaria from the atmosphere by inhalation and skin absorption be true, and disease be the result, it is as reasonable to suppose that water can absorb and retain it, and when drank in quantities will have the same deleterious effect. Hence, he terms what was previously known in the mountains as "mountain fever," "malarial remittent." He says:—"Having thus identified mountain fever as a malarial intermittent, and referred it for causation and explanation of its peculiarities to the ingestion of malarious water rather than to exposure to malarial exhalations, there opens for our consideration a larger view than is seen in the slopes of the Rocky Mountains. The necessity for a modification of our accepted theory of malarial disease is apparent. Lancisi's doctrines are too exclusive. Water must be recognized as claiming a higher place in the disease-producing category; and the importance of this recognition can not be overestimated."

Now, this is not only a new theory for the induction of malaria into the system, but rather a plausible one, and I will not attempt to contradict it. Yet I can not altogether agree with the surgeon, that malaria was the sole factor in the production of his mountain fever cases; and I think we can ac-

count for the typhoid element in the fact that the men were in all probability deprived to some extent of healthy food, were exposed more or less to the severe weather prevalent in that high latitude; that they suffered no doubt in disquietude of mind, from home sickness, etc., all of which are calculated very greatly to depress the nervous system, and thereby act as a cause of disease. Might not such surroundings, in conjunction with malaria, produce diseased action simulating what we understand to be typho-malarial fever? I can not help concurring in the views of Surgeon Woodward.

As far as my observation goes, the disease under consideration differs somewhat from "typhoid fever," not only in its symptoms but in its subjects. In true typhoid, it is rarely you see a case over forty-five years of age; but in the few cases I have seen of typho-malarial fever, three were over fifty years old, but nevertheless the most of them were young. I think also that the pulse is not so frequent, in proportion to the temperature, as it is in typhoid fever. This was especially exemplified in the case of Mr. R., whose pulse never became more frequent than in health, and as the disease gave way became as low as fifty, which would have alarmed me had not all other symptoms been favorable. I have not yet seen a case where the diarrhœa was uncontrollable, although in several instances I have been compelled to use astringents. Delirium is not so common as in typhoid. I had one case, however, who was entirely delirious for over a week. The heart acts with better force, but not so frequent. The extremities, I think, keep warmer. In many cases we have the sordes on the lips and teeth, but not so universally as in typhoid. The tongue rarely becomes so dry, pointed, red and glazed, but is more apt to be flabby, large, with red edges, and coated at first with a whitish fur. Tympanitis is frequently present, but not so common as in typhoid. I do not recollect of noticing borborygmus. In most cases, for the first week, there is but little desire for food. The urine in general is diminished in quantity, and rather high-colored. As to its constituents, I have not made an examination to

ascertain whether it deviates in any particular from a state of health. I have not seen a case complicated with any other disease, and therefore think it not so liable in that respect as typhoid, although this may in a great measure depend on the season of the year in which it prevails; typhoid fever, on the other hand, prevailing at the time of year when its usual complications are more liable to occur. As to the duration of the disease, I think there is but little difference between it and typhoid, both diseases continuing from three to seven weeks.

I have had no opportunity to examine into the pathology of the disease, no doubt a careful study of which would throw much light on its true character. I can not think that it is a true enteric fever, as we ordinarily understand that term, but no doubt the prima via is to some extent involved, and forms the typhoid element of the disease. As I have seen comparatively but few cases of typho-malarial disease, and may have from such limited observation failed to have drawn correct conclusions in regard to its true character, I hope my brethren in the profession will contribute the knowledge they may have gained by a more extended observation and larger experience.

From the tenor of Surgeon Smart's remarks, he is inclined to believe that the majority of the cases of mountain fever, so called, are simply neglected cases of remittent, and under quinia treatment in the outset would have given way. He as much as says that the cases coming under his care, in the onset of the disease, were subject to the control of quinia. Now, if this were the case with the patients under his care, I am confident they varied somewhat from the type of the disease under consideration; for it has been my invariable practice to administer quinia in full doses, repeated at short intervals, until I see no utility can be derived from its further use in that way, and by this means determine positively the character of the trouble I have to treat, hoping it may be only remittent and thereby break it up.

As to neglected remittents, I have had a limited experience

in their treatment. Over thirty years ago, when I commenced the practice of medicine, remittent fever was treated very differently from what it is now. The old practice was to bleed, vomit, purge, mercurialize and blister; and in the course of ten days or less, in many instances, we had the typhoid element developed, simply from irritation or subacute inflammation of the bowels. It may be said that these were not neglected cases; they were worse, and as far as I have observed more unmanageable, when having been treated in this heroic manner than those receiving no treatment. There is no doubt that in neglected cases the fever has a tendency to involve the bowels, which constitutes the dangerous element of the trouble. Under the old régime, what few cases I saw, which terminated fatally, this result was brought about by involvement of the bowels. I have no doubt many cases of simple remittent have, by maltreatment or neglect, terminated with typhoid symptoms, and been set down either as typhoid or typho-malarial fever. And possibly the cases coming under the care of Surgeon Smart, at Fort Bridger, may have been neglected or previously badly managed cases of simple remittent, without the typhoid element existing in the outset. Should these have been the facts in his cases, probably his theory of mountain fever is correct.

Now, as to the *cause* of this typhoid element, I have not as yet satisfactorily determined. At the house where I saw the first cases in 1875, there was apparently nothing in the surroundings to indicate any such cause in action. The house is under-pinned with rock, and as the summer had been an unusually wet one, the water may have, and no doubt did to some extent flow under it, and settling and being confined, doubtlessly produced the malarial element of the disease. The residence is situated on a high knob, some two hundred and fifty feet above the level of Salt River bottom, and had been heretofore comparatively free from all malarial trouble. But, in this instance, we have yet to account for the typhoid element; and I can only do so on the hypothesis that the spring which afforded the water supply was situated slightly

down the hill, and owing to the excessive rain had washed into it some *materies morbi* from above. The stable and hog-pen being situated higher than the spring, yet not immediately above it, may have contributed their share in contaminating the water. The cases occurring at this house were the only ones I saw or heard of in the practice of any of my neighboring physicians during said year. I have heard of no malarial trouble in that family since.

At the house of about the worst patient I had in 1876, at least who had the severest typhoid symptoms, viz., diarrhœa and delirium, I noticed that around the cistern, which was situated just in front of the kitchen door, a great deal of kitchen offal, slop, etc., had been thrown, and in a state of fermentation. No doubt a great deal of the strength of this fermenting mass of vegetable and animal matter found its way through the cistern-wall by percolation, and contaminated the water. This patient was the only one at the house affected with this disease, and she drank more of the water than any two of the family. The house is located in the Ohio Valley, where generally a plenty of malaria exists.

It may be, had I examined closely the premises of all the patients I saw, I could have, in some degree, satisfied myself as to the cause of the typhoid element of the disease; but as this disease occurs at the season of the year when we have a great deal of malarial disease to attend to, our time for investigation is somewhat limited.

Though this disease has not increased in my practice since I first saw it, yet I hear of its increase in the practice of several of my neighboring friends, and feel confident that it will become an annual trouble in our section of country. Hence the necessity of further investigations as to its cause, as well as its nature and treatment.

Ord, Jefferson Co., Ky.

FOUR HUNDRED OBSTETRICAL CASES—STATISTICS AND OBSERVATIONS.

BY G. W. H. KEMPER, M. D.

In the following paper I propose to study the history of four hundred obstetrical cases occurring in my practice during the past few years. I think they will be of some value to obstetrical literature, from the fact that they occurred in a rural district among a healthy population. I have made no selection of cases, simply taking my first four hundred recorded in the case-book, excluding only consultation and premature cases, in order that an impartial record might be made.

The largest number of labors (forty-nine) occurred in August, and the least (twenty-three) in February. Two hundred and sixty-three of the cases were multiparæ, and one hundred and thirty-seven primiparæ. Of the presentations, three hundred and ninety-one were cephalic, fifteen breech and footling, and two shoulder. Seven of the women were colored.

Of the fifteen breech and footling cases, twelve children were saved and three lost. Four times this presentation occurred with one of twins; and in one case, both—*i. e.*, five of the entire number—occurred in twin cases.

One of the two shoulder presentations was complicated with a prolapsed cord, and occurred in a twin case—first child. I performed version, and saved the child. In the second case, the woman had been in labor for some hours; I turned and delivered a still-born child.

Version was performed in three instances, including the two cases of shoulder presentation. In the case of the twins, after I had turned and delivered the first child, the second presented by the vertex and a hand, with the further complication of detachment of the placenta, which was presenting in advance of the head. I performed version immediately. The twins were both females. The second one was still-born. In the single case, the child (a male) was still-born.

I met with twins eight times, that is once in fifty cases. In five of the cases, one presented by the breech and the other by vertex; in one case, both by the breech; in one, the first by a shoulder and the second a vertex; and in the remaining one, both by vertex. In three cases, one was a male and the other a female; in four, both were females; and in one, both males. To sum up, eleven were females and five males. All the children were saved except the one mentioned under version.

I encountered two cases of prolapsed funis. One was in the twin case mentioned. Version was resorted to, and the child saved.* The second occurred in a vertex presentation, and the child was still-born. In one of my footling cases, the cord was around the thigh, and contributed to the child's death.

Convulsions occurred five times. Four of the cases were primiparæ, and one a multipara. In three cases convulsions began before delivery, and in two afterward. The maternal mortality was one; of the children, four were saved and one lost. The sex of the children stood four females, and one male. The fatal case presented some points of interest.

Mrs. W., aged twenty years, primipara, after an easy and in every respect natural labor, gave birth to a female child at one o'clock A. M., December 19, 1870. Not an untoward symptom presented until the evening of the third day after confinement, when she laughed violently at some little incident for a few moments, and then passed into a convulsion. Others recurred at irregular periods, and all of that variety termed by some writers *hysterical*. Chloroform and the usual remedies were

* "Simple reposition of the cord by the fingers of catheter, the patient being in the genu-pectoral position, often succeeds; but I believe that, of all the modes of treatment recommended, the most successful, as regards the child, is turning. Thus, of sixty-four cases—in the practice of La Motte, Mauriceau, La Chapelle, Boivin, Shekleton, Giffard, and McClintock—where turning was resorted to solely on account of the funis presenting, fifty-two of the children were born alive. This list does not include cases where the hand or arm presented with the cord, nor those in which the child was apparently dead when the operation was undertaken. No other plan of treatment can show such good results as this." (McClintock, note in Smellie's Mid., new Syd. Soc. ed., Vol. I, p. 341.)

faithfully tried, and although the type might have been considered the most favorable, and notwithstanding each succeeding paroxysm grew milder, nevertheless she gradually sank and died on the evening of the 25th.

If we occasionally are surprised to see a case of apparently mild convulsions terminate in death, we are more often surprised to see desperate cases recover. I beg of younger physicians never to abandon any case of puerperal convulsions, however hopeless it may appear, until death actually ensues; a practice of a few years will confirm the wisdom of this rule, and its observance will win laurels for the practitioner.

Post partum hemorrhage occurred in five cases. Since I have adopted the custom of administering to every multipara a full dose of ergot at the termination of labor, I have had no troublesome hemorrhages.

I met with five cases of adhesion of the placenta:

Case I occurred at a second labor, and I had considerable difficulty in detaching the placenta. She told me the same trouble occurred with her first labor, when counsel was summoned from a distance to remove it.

Case II was a primipara. She has been confined since with her second labor, and the attending physician removed the placenta with much difficulty.

Case III was with a fifth labor, and was the most troublesome and difficult case I ever encountered, as it adhered so firmly that it was difficult, as Barnes says, to determine the boundary line between the uterus and placenta, so intimate a union had taken place between them. Adhesion of marked firmness occurred with three of her former four labors, and she has been confined again quite recently with a sixth labor, and I was compelled to remove the placenta by introducing my hand. In her six labors adhesion was present with five.

Case IV was with a fourth labor, and was the only time adhesion had been present.

Case V was with a second labor, and adhesion had occurred with her first.

I have long since been convinced from observations that

placental adhesion is a complication which is very prone to recur in successive labors. My cases confirm my opinion.

I used forceps twice, both in cases of convulsions. The women were primiparæ, and recovered without an untoward symptom. The children were females—one born alive, the other still-born. After an experience of thirteen years, as I look back over my professional life, I call up cases which I met with in my early years when from timidity I failed to use the forceps—trusted to nature, found her inadequate to the task, and result a still-born child. A better experience of later years has convinced me of the advantages of the forceps. During the last two years I have used them several times with satisfaction, and as a number of appeals have recently been made to the profession for a more general use of the forceps, I desire to record my experience in their favor. During the last three months I used forceps in two cases where, I have good reason to believe, I saved the lives of two children, and the mothers a great deal of unnecessary pain. The opposition to forceps by non-professional persons is fast dying out; in fact, I expect to see the day in this community, and that not many years hence, when the friends of the lying-in woman will *demand*, in tedious cases, that the forceps be used for her relief and the safety of the child.

Three deaths occurred in the four hundred cases. One from convulsions—case of Mrs. W., mentioned before. One of general debility, the patient being enfeebled by two former abortions and nursing sore-mouth. The third died from pneumonia, the initiatory chill of which excited labor, and she was delivered the same day, and died nine days afterward; properly speaking, this case might be excluded from the list.

In the four hundred labors, four hundred and eight children were born; two hundred and eight of whom were males, and two hundred females. All were born alive except thirteen, eight of whom were males and five were females; seven occurred with primiparæ, and six with multiparæ. The presentations were as follows:—vertex nine, shoulder one, and breech three. The causes of death I reckoned as follows:—tedious

labor, eight; putrid, one; prolapse of funis, one; early detachment of placenta, one; unknown, one; debility of the mother, one.

A few peculiarities might be mentioned in conclusion of my paper. Of the whole number of births, five were illegitimate. One case was complicated with erysipelas of one of the legs to such an extent, that nearly all the skin and cellular tissue from the ankle to the knee sloughed off. Several large ulcers were left and refused to heal, and the leg was amputated a few years afterwards.

I had one patient, whom I attended in three labors, where for the first two days milk appeared in the breasts, and then disappeared without again forming. This was the case, she informed me, in four former labors.

In one case, the removal of the placenta did not color my hand, and no lochial discharge was present. The patient, a primipara, had not an untoward symptom.

I met with one case of spina bifida, complicated with other deformities. The child lived for two weeks. No severe laceration of the perineum occurred.

One case of œdema of the vulva necessitated numerous punctures to evacuate the serum, in order to permit the passage of the child.

I met with one case of inversion of the uterus coincident with the expulsion of the placenta. The after-birth was firmly adherent to the fundus, and after separating it I immediately reduced the inversion. This case has been more fully reported elsewhere.*

I met with two cases where I saw no reason to doubt that the health of the mother was impaired by the presence of a retained fetus. One, for some time before as well as after giving birth to a putrid fetus, had unmistakable symptoms of septic poisoning. The other case was a remarkable one, and I have reported it at length in a former paper, entitled "Retention in utero of the dead fetus," etc.†

MUNCIE, IND.

* Indiana Jour. of Med., Vol. IV, p. 482.

† Trans. Ind. State Med. Soc., for 1875, p. 23.

INTRA-UTERINE PREGNANCY, COMPLICATED WITH EXTRA-UTERINE FETATION—RECOVERY.

BY J. M. DE ROSSETT, M. D.

Mrs. M., a large, rather tall, and an exceedingly robust woman, aged twenty-seven years, married four years, primipara, menstruated at sixteen, and enjoyed excellent and uninterrupted health, date of last menstruation some time in November preceding my first visit, was seen by me March 26, 1876. I found her suffering most excruciating pain in the right iliac region. She had had pain in this locality during the past month at intervals, though not very severe and usually controlled by domestic remedies; she supposed herself to be pregnant. Inspection revealed a tumor rather low down in the right iliac region, as large as a small fetal head, firm and solid, and encroaching somewhat upon the median line. The surface of the abdomen beyond the tumor presented nothing unusual.

A digital examination revealed the os soft and patulous, with but little development. There also existed right latero flexion to a moderate extent, with the uterus somewhat enlarged and adherent to the tumor. The uterine sound was not resorted to as a means of diagnosis. There were also present in the mammary glands changes indicating pregnancy, with morning sickness, etc.

On the 28th of March, two days after my first visit, there appeared a slight sanguineous discharge, lasting for one day. The pain was controlled by opiates, and gradually disappeared after seven or eight days. The tumor continued to enlarge for about one month after my first visit, and then ceased to grow, and did not again take on development. At this time the tumor had attained the dimensions of a large fetal head. The case was seen and examined by several medical gentlemen, among whom contradictory opinions were entertained as to the nature of the tumor.

After a careful review of the history and symptoms above referred to, it appeared to me that I had one of two things to deal with, viz., either an ovarian tumor or extra-uterine pregnancy: the latter seemed to have the more evidence in its favor, and I adopted this diagnosis. After the cessation of the pain her condition was comparatively comfortable, but the uterus continued to enlarge after my first visit.

During the latter part of April, fetal movements were felt in the uterus, the outlines of which were well defined, and occupied a central position. This had no effect on the tumor other than to slightly obscure the outlines along its uterine border. Intra-uterine pregnancy was now a fixed fact, but the original tumor remained a matter of doubt. However, I was now inclined to change my diagnosis from extra-uterine pregnancy to intra-uterine pregnancy, complicated with ovarian tumor. I then anxiously awaited the period of the patient's accouchement.

On the morning of August 5th, I was summoned to attend the patient, and found her in the first stage of labor, the os dilated but little and dilating slowly, with breech presentation, the uterine contractions being rather feeble. I now availed myself of the opportunity to inspect the abdomen during the contractions of the uterus, and the following is what occurred: Beginning with each contraction, there appeared a deep sulcus or groove along the line of contact of the uterine and iliac tumors, sufficient to receive a body as large as the index finger, the sulcus disappearing on the cessation of the contraction.

At four o'clock P. M. dilatation was complete, membranes ruptured, and a moderate amount of liquor amnii discharged. The second stage of labor was protracted, owing partly to my inability to deliver the head promptly. At seven P. M. the patient was delivered of a dead female child, weighing about seven pounds, and well developed.

I had anticipated post partum hemorrhage. A short time before the second stage of labor was completed I administered ergot, and subsequently employed Crede's method for the separation and expulsion of the placenta; but in that I was

disappointed. A rather free hemorrhage admonished me to remove the placenta immediately, which I did.

The uterine contractions during the third stage of labor were feeble, and on introducing my hand within the uterus I discovered that the placenta was attached to the right lateral wall and fundus of the uterus, exactly at that point of the uterus in contact with the tumor. The placenta was with some difficulty detached and removed, after which considerable hemorrhage occurred from the want of sufficient uterine contractions. Hemorrhage continued to occur at intervals for the next two weeks, and was with difficulty controlled, though not alarming as to quantity at any time after the first twenty-four hours. Nevertheless, by its continuance, it rendered the patient's condition very critical, producing an extreme degree of anemia and debility. The tumor remained much the same after the uterus was emptied, with the exception that it became more prominent and its outlines better defined.

Two weeks after labor septicæmia set in, which defied all treatment, notwithstanding the most energetic measures were resorted to, both local and constitutional. After four weeks' treatment, with no improvement and the patient's condition becoming daily more hopeless, with dissolution likely to occur at any hour, she became disgusted with treatment, disheartened with no prospect of recovery, she became reconciled to her fate, and refused to continue further treatment.

In this condition she remained some three weeks, gradually sinking lower and lower. The odor about her bed and person, which had hitherto been controlled during treatment by disinfectant solutions, now became so offensive that her friends could scarcely remain near her.

About the 15th of October, something was discovered protruding from the vulva. A physician was called in, one previously in consultation in the case, who removed a part of what proved to be the remains of a fetus, supposed to be near the fifth month of gestation, and in an advanced stage of decomposition; nevertheless, the placenta and cord were plainly discernible. It was also discovered that this product

gained egress through the os uteri. Portions of this product continued to be discharged from time to time, together with pus and débris. The tumor undergoing marked diminution from the first escape of the putrid mass, and the general health and condition of the patient improving in a corresponding degree, the successful effort of nature to get rid of the offending mass, coupled with judicious treatment, enabled the patient to take a new lease on life, and four months from this time she was in the enjoyment of vigorous and robust health, with not a vestige of her former trouble remaining.

GREENUP, KY.

DOUBLE FETATION.

BY S. M. LINTON, M. D.

On the evening of May 23, 1869, I was requested to visit Mrs. N., aged nineteen years, a primipara. I was informed by her mother that "they supposed Mrs. N. to be pregnant since the latter part of January; that she commenced wasting in the morning, and was now flooding fearfully." I found the patient propped up in bed, and well nigh exsanguine. I immediately removed the pillows from under her head and shoulders, and ordered the foot of the bed raised some ten or twelve inches. This done I made a digital examination, and found the mouth of the womb dilated to the size of a silver half dollar, and readily detected a central placental presentation. Her condition was such that I deemed it advisable to use the tampon, which was thoroughly applied, entirely arresting further drainage. This accomplished I took a seat to await results, remaining by her bedside until the next morning; and as there was neither hemorrhage nor pain, I enjoined perfect quiet, and left with instructions to be summoned if necessary. I did not see her again until six o'clock in the

evening, when I found her in active labor pains, and soon tampon, placenta and fetus were expelled. I also removed from the vagina a well compressed coagulum, the size of a hen's egg, being the entire amount of hemorrhage occurring since the application of the tampon. From this on, my patient made a rapid recovery, and the case faded from my mind as one of placenta prævia with fortunate termination.

On the thirtieth day of October following, I was again summoned to visit Mrs. N. This time I found her in active labor, and within two hours from the time of my arrival she was delivered of a live female child, weighing nine pounds and eight ounces. The child is now a bright little school-girl of nine summers, her birth taking place just five months and six days after the unfortunate expulsion of her twin sister.

Placenta prævia, with excessive flooding, use of tampon, expulsion of the dead and retention of the living twin to full term, are points of professional interest.

COLUMBUS, IND.

Reviews.

The Science and Art of Surgery—Being a Treatise on Suegical Injuries, Diseases and Operations, By JOHN ERIC ERICHSEN, F. R. S., F. R. C. S. Revised by the author from the seventh and enlarged English edition. Illustrated with eight hundred and sixty-two engravings on wood. Two volumes. Philadelphia: Henry C. Lea. 1878.

The announcement of a new edition of Erichsen's Surgery will be received with great pleasure by the profession. Its coming will undoubtedly be considered the great surgical event of the year. The work has grown no less in size than in favor since its debut twenty years back. What was then embraced in a single modest volume, seeking favor of English eyes alone, demands now two large octavos of nearly a thousand pages each, and the treatise is accepted as a standard authority by the world of surgery. Many rivals have, from time to time, entered the lists against it, but it has maintained its reputation against all comers. Even the ambitious volumes of Holmes, which contained the efforts of various masters, failed in giving a competitor superior to that of the great pupil and follower of the illustrious Liston.

It is a matter of much pride to Americans that the only work which, it may be safely said, has found favor in comparison with that of Mr. Erichsen, is the massive work of our own countryman, Gross.

We can recall few instances where either medical or surgical authors have continued to have a hold upon the profession like that of Mr. Erichsen. Paget, in Pathology, is classical, indeed; but he does not give the last word. Watson's Physic, though it is as it should be in every modern library, began to be supplanted twenty years ago.

Many circumstances, no doubt, have contributed to the exceptional fortune of Mr. Erichsen. Among those which are most apparent we may mention that he begun life very early as an author, and showed at the outset the powers of a master. Himself one of the busiest of the actors in the theater whose exploits he records, with a mind singularly judicial and appreciative of the labors of others; with an industry untiring, and with powers of expression unsurpassed, he has never allowed his work to grow old—has never failed, at proper intervals, to record the advance of his art. The seventh edition of his work follows in quick succession on the sixth; but surgery has been in such an excited condition of late that a few years may bring with them much that is to be renewed. Fresh exploits are to be recorded, and old methods and theories are to be examined by better analysis.

The surgical records of our unhappy conflict, compiled by the indefatigable and judicious men in the Surgeon-General's office, constituted, indeed, a master-piece in the military department of our art; but great wars have convulsed Europe since then, and yielded there at least additional experience. And though such experience may not apparently figure largely in a work not intended especially for military surgeons, lessons furnished in hygienic and operative fields could not but have had a powerful influence upon our art as applicable to civil needs.

The theaters of civil surgery have, too, been busy. Operative surgery has been pushed to such an extent that, in the words of Mr. Erichsen, it has apparently reached a finality. Specialism, which has grown to be a separate and powerful estate, has added the cunning of its concentrated skill to certain departments of surgery.

New conditions have been afforded the knife and its exploits. For twenty-five years it was its greatest triumph that it might cut without pain. Then arose the question whether the division of tissue need be followed by pus and its waste. Quickly following this, it was demonstrated that in many instances blood need not flow from its use.

Nor was pathological surgery ever more fairly up, and the claims of surgery to rank as the acme of medical science. Day by day the vigorous analysis of the microscope and the test-tube have been pushed, and the results obtained compared with bedside experience to advance our knowledge of the cause and cure of surgical disease. Surgery, in fine, has caught the full fervor of the times, and no branch of human knowledge has more rigorously demanded a searching review of the whole ground upon which it stands.

Mr. Erichsen brings to the work of his seventh edition the ardor of his youth, and the philosophy of his mature years. No words can better express the spirit with which he has entered it than his own.

"A teacher of surgery," says he, "who seeks to give a true and impartial view of the subject of his tuition, is placed in much the same position as a judge who is summing up a great cause."

And no one who reads his present pages can deny that he has kept his model before him. He has, in the first place, rid himself of the bias of any views he has hitherto held in surgery, and pruned as well as added to his work. As he says again in his preface:

"He must endeavor to divest himself of the trammels of the schools—to free himself alike from the partisanship of individual bias and the antagonism of professional prejudice. He must lay down clearly the broad general principles on which the case rests; detail its facts in an orderly and succinct manner, draw those deductions which legitimately flow therefrom, and guide his pupils to arrive at just conclusions by the light of his own more matured and extended experience."

The first change in the old text is made in the second page of the new edition, where the author introduces some of his remarks made a few years since at University College, concerning the "finality" of operative surgery, about which so much discussion was had at the time. Under the head of "Conditions influencing the success of operations," he gives the "four classes of primary surgical urgency," which we quote as an example of the author's comprehensive style:

"Patients with a high temperature should never be operated on

except for the relief of that very condition which occasions the elevation of temperature, such as the accumulation of pus, or in one of those four great surgical emergencies that demand, under all and every circumstance, immediate operation, viz., first, dangerous hemorrhage; second, impending asphyxia; third, strangulated hernia; fourth, over-distended bladder."

The remarks on hygiene have been much extended, and Tyndall's and Pasteur's experiences have been noted. Under "Anæsthetics," Ether receives more attention. In the "Performance of an Operation," Esmarch's method is described and favorably commented on. Although the author here notices Langenbeck's remarks upon symptoms of paralysis following the use of the elastic bandage, he fails to note the application of electricity, which has served so well to stop the oozing of blood resulting from this cause.

The chapters on Amputations have been rewritten, and other methods besides that by flaps have been considered. The woodcuts in this chapter are particularly bold and faithful.

The chapters on the inflammatory process have received some attention—more in the rearrangement of the type than in additional text. In the consideration of wounds much valuable matter is added. The question of bacteria is well discussed. And concerning Mr. Lister's theory and practice, to which Mr. Erichsen gives a partial adherence, under the head of "Antiseptic Treatment," he gives the following wise conclusions:

"The introduction of the 'antiseptic treatment' being cotemporaneous with the general adoption of improved hospital hygiene, the patients subjected to this method necessarily participate in the advantages that flow from exposure to sanitary conditions that have been so much altered for the better. Hence it is not reasonable or just to ascribe a diminution of the amount of septic disease in a hospital in which the 'antiseptic method' is employed, to that alone, and to the exclusion of all other causes. Either hygiene is of no value in surgical cases, or some and probably no inconsiderable share in the improved results must in justice be assigned to the generally ameliorated sanitary conditions. The only compari-

son that can justly or scientifically be instituted, is between one set of patients treated antiseptically, with another of a similar kind subjected cotemporaneously to other methods of treatment. . . It is manifestly unscientific to compare the results of modern with those of older methods of surgical practice, even in the same institutions, where the attendant conditions, independent of mere treatment, are dissimilar; and it is equally incorrect and unjust to refer all improvements in results to one only of the many improved conditions to which the patient is now subjected."

The chapters on Fractures have been somewhat remodeled, not to the extent, however, which we would have thought, in view of the advances made in the management of these injuries. The profession is indebted to Mr. Erichsen, perhaps, more than to any other man, for sound views upon the pathology of fractures. It was by his teachings that the fallacy of active extension and counter-extension was exposed, and his example, along with the utterances of Billroth, gave the chief impulse to the spread of plastic dressings. We venture to think that our author would have improved upon his present remarks on this subject had he omitted the detailed account he gives of the "starch dressing," and substituted for it a fuller description of the newer and better methods of applying the paris-plaster, and made mention of the several other pastes, as that of flour and eggs, and glue and zinc, for instance, both of which, in our opinion, are notably superior to that of starch. The latter indeed may, we think, be fairly considered as obsolete. His caution concerning bandages under splints and over the seat of fractures, were not as clear as they might have been in previous editions, and have not been made more so in this. We further venture the remark that he pays too much respect to sundry methods of treating the same fracture: simplification and not amplification would have been the proper step.

But interesting as it would be to note the many other changes contained in the present volume, the limits of our space have been reached. Besides, the day has long since gone by when Mr. Erichsen needed to be endorsed. We trust that we have called attention to the freshness of the

work, if to nothing else. What we have said in our author's praise we could not keep back.

The seventh edition is before the world as the last word of surgical science. There may be monographs which excel it upon certain points, but as a conspectus upon surgical principles and practice it is unrivaled. It will well reward practitioners to read it, for it has been a peculiar province of Mr. Erichsen to demonstrate the absolute inter-dependence of medical and surgical science. We need scarcely add, in conclusion, that we heartily commend the work to students that they may be grounded in a sound faith, and to practitioners as an invaluable guide at the bedside.

The liberality of author and publisher has been lavished upon the work, and its mechanical execution is admirable.

Public Hygiene in America—Being the Centennial Discourse delivered before the International Medical Congress, at Philadelphia, September, 1876. By HENRY I. BOWDITCH, M. D., with extracts from correspondence from the various States. Together with a Digest of American Sanitary Law, by HENRY G. PICKERING, Esq. Boston: Little, Brown and Co. 1877. 8vo., 498 pp.

The centennial address of Dr. Bowditch, as delivered to the International Medical Congress, in September, 1876, has already been published and distributed by the authority of the Congress. This book is an extension of the address, with a multiple appendix, containing much of the correspondence and other papers and facts on which the author relied for the substantial foundation of his discourse.

The first part of Dr. B.'s address is devoted to the history of American medical ideas during the century ending with the year of his speaking. He divides this period into three distinct epochs:—the first from 1776 to 1832, in which the medical doctrines taught by Broussais in Europe, and Rush in America, were dominant. These doctrines may be fairly

limned by quoting the expressions of Dr. Rush, when he said to his class, "turn nature out of doors, gentlemen, and appeal to art;" and "Cullen's *vis medicatrix naturæ* is a mere delusion;" and "the time must and will come when the general use of calomel, jalap, and the lancet, shall be considered among the most essential articles of the knowledge and the rights of man."

The second epoch, from 1832 to 1869, "commences the rise of more exact and scientific methods of study, with most minute observation of facts, and subsequent analysis of such facts, without the least regard to preconceived opinions." "Louis of France, Forbes of England, Bigelow and Bartlett of America, will be seen as the eminent exponents of this period."

The third epoch began in 1869, and our author projects it into the future without prevision of its limit, and he ascribes to it a nobleness and a beneficence transcending everything in the past. Prevention of disease is the paramount purpose of the present period, as the cure of disease was almost the only thought of the past; and our author, as was his appointed duty, gives the point of his discussion to State Preventive Medicine, and dates this epoch from 1869, because in that year Massachusetts created a State Board of Health, the first of its kind in America. He names Lemuel Shattuck of America, and Edwin Chadwick of England, as the pioneers in this highest development of medical science; but he mentions many others as invaluable coadjutors in the noble work. This first part of Dr. Bowditch's address is a concise and terse piece of composition.

On the first of January, 1876, Dr. B., as a preliminary step, wrote a series of questions—principals and subsidiaries—numbering forty-seven, to two hundred and sixty-three medical men, living in all the states and territories of this Union, and from them received one hundred and seventy-nine replies; and the second part of the address is an analysis of this correspondence. These queries cover a call for information concerning the past and present condition of state medicine, with

an invitation by Dr. B. to his correspondent to forecast the future in this behalf in their respective localities. The analysis of the information thus obtained is quite instructive; *albeit*, it is far from flattering in regard to the extent of the cultivation of our people in this behalf. Nevertheless, there is room for congratulating ourselves in the fact that we have begun our new national century with a bright awakening to the importance of the duties and the privileges of our situation.

In closing his summary, Dr. Bowditch portrays his sense of the grandeur of his theme and the magnitude of the service in prospect for us in the following forcible paragraph:

"We stand now at the very dawn of the grandest epoch yet seen in the progress of medicine. While philosophically, accurately, and with the most minute skill studying, by means of physiology, pathological anatomy, chemistry, the microscope, and above all by careful clinical observation, the natural history of disease and the effects of remedies, our art at the present time looks still higher, viz., to the *prevention of* as well as to the *cure of* disease. And this is to be done by sanitary organizations throughout each state; the nation, the laity, and the profession heartily joining hands in this most noble cause."

About one-fourth of the volume is occupied by the address; the remainder is taken up with the appendix in eight parts:

Appendix I is the twenty principal and seventeen subsidiary questions of the circular of inquiry, and the names of the parties to whom it was addressed.

II. Is constituted of the answers to the queries from all parts of the states and territories, many of them from the most noted students of state medicine in the profession. The answers are arranged by states, and embrace every phase of the many-branching subject.

III. Is public hygiene in the universities and colleges.

IV. Is the digest of American sanitary law, by H. G. Pickering, attorney-at-law. This treats first of the United States, and then of each state in alphabetical order, and will be found

of great utility to those who are seeking to inaugurate state medicine in the thirty-eight states and territories where it does not now exist, or are striving to advance it in the ten where it has already been started.

V. Is entitled Louis and Pierson on Dr. James Jackson, Jr.

VI. Is the law of soil moisture, being the author's investigation and report on soil moisture as a cause of consumption.

VII. Is the Massachusetts law on noxious and offensive trades.

VIII. Is a brief statement of European sanitary work.

Various salient points in the volume present tempting opportunities for special comment, but the effort made in this notice has been to give such a chart of the book that the reader may know enough about it to decide whether it is one he desires to have in his library; and hence the temptation to comment has been resisted lest the notice become too long. It is a work in which the general practitioner will meet with much to interest him; and it will be peculiarly valuable to the student of general sanitary measures, state boards of health, and preventive medicine. J. F. H.

Contributions to the History of Medical Education and Medical Institutions in the United States of America, 1776-1876. Special Report. Prepared for the United States Bureau of Education, by N. S. Davis, A. M., M. D. Washington: Government Printing Office. 1877. 8vo., 60 pp.

In 1874, the United States Bureau of Education published a history of the progress of medical education prior to the Revolution, prepared by Dr. J. M. Toner, of Washington, D. C.; and at his request Dr. N. S. Davis, of Chicago, was invited to write a like history for the century ending with the year 1876, to constitute a part of the material to be furnished by the bureau to the Centennial Exhibition of that year. Dr. Davis accepted the invitation, and this pamphlet is the product of his labor.

Dr. Davis probably has no superior for a work of this kind; and in this instance he began with an account of the condition of the colonies in 1776, containing about three million inhabitants, of whom something over three thousand were physicians, with two medical colleges, two organized medical societies, and one permanent general hospital. Following the development of medical education from this narrow base, our author gives, with some minuteness, the establishment and organization of the medical schools up to 1876, when there were sixty-four in active operation. In 1810, the whole number of medical students was six hundred and ten, the graduates for that year about one hundred; in 1876, the number of students was six thousand six hundred and fifty, and the graduates twenty-two hundred.

The *brochure* is divided into two parts. The first treats of teaching as above; the second part, with equal care and attention to details, gives the history of the more important medical society organizations.

Parties desirous of meeting with facts covered by the caption of this book, will find them here presented with the perspicacity and force peculiar to its author. The sixty large octavo pages are loaded with much wheat and but little chaff.

J. F. H.

The Action of Medicines. By ISAAC OTT, A. M., M. D., formerly Demonstrator of Experimental Physiology, University of Pennsylvania. With twenty-two Illustrations. Philadelphia: Lindsay and Blakiston. 1878. 1 vol., 8vo., 168 pp.

The object of this little volume appears to be "to give those engaged in teaching and experimenting a text-book that will give some idea how to investigate the action of drugs." Those, then, who purchase it expecting to get a treatise on the action of medicines will be disappointed, and it is rather unfortunate that the author should have given this title to his book. The volume contains four chapters.

Chapter I. How to study the physiological action of medicines. This is full of practical matter that can not fail to be interesting to any one engaged in this difficult path of medical investigation, and the directions given as to apparatus and manipulations must prove most valuable.

Chapter II gives information and directions how to study the action of medicines on the nervous system.

Chapter III deals with the methods of investigating the action of medicine on the circulatory apparatus, and both these chapters also contain many physiological facts essential to the perfect understanding of the action of medicines. This occupies one hundred pages of the book, or nearly two-thirds.

The remaining sixty pages deal with the action of individual medicines upon man and the lower animals. It is very imperfect, giving, in most instances, a most meager synopsis of facts, which must be entirely inadequate to meet the wants of those for whom the book is ostensibly prepared. Looseness, not to say slovenliness of style, is particularly objectionable in scientific works; and its pages are here and there marred by such defects, as when the author, speaking of frogs, says, "their apparatuses are able to survive for some time the destruction of each other." If the different "apparatuses" of the frog are ever engaged in "the destruction of each other," it is at all events pleasant to know that they are able to survive the massacre for some time. Fortunately the puzzle is solved in the context. Many important remedial agents are not even mentioned by name.

The book, though not devoid of merit, is hardly practical enough for this side of the Atlantic. It is neat and attractive in appearance. J. A. O.

Guy's Hospital Reports. Edited by H. G. HOWSE, M. S., and FREDERICK TAYLOR, M. D. London: J. and A. Churchill. Third Series. Vol. XXII, pp. 527. 1877.

The contents of this volume are so rich and varied that in the short space that can be given to it an extensive review is

impossible. Among the most important articles are those on Cerebritis, Hysteria and Bulbar Paralysis, as illustrative of arrest of the function of the cerebro-spinal centers, by Samuel Wilks, M. D.; some relations of Mental Disease to Inheritance, by George H. Savage, M. D.; Empyema and its Treatment, by James Goodhart, M. D.; some cases illustrative of the diagnoses of diseases of the Cœcum, by S. O. Habershon, M. D.; on the Nervous System in Diabetes, by Fred. Taylor, M. D., and James F. Goodhart, M. D., etc. These papers all deserve perusal, and some of them are exceedingly valuable.

The surgical part is chiefly made up of a report on Tumors of Bone, with illustrations, Cyst in Shaft of Tibia, and Osteitis Deformans. J. A. O.

Practical Gynecology—A Hand Book of Diseases of Women. By HEYWOOD SMITH, M. A., M. D., etc. Philadelphia: Lindsay and Blakiston.

Dr. Heywood Smith needs no introduction to the readers of the American Practioner. His very interesting article in this journal, August, 1877, has made his name known, by all who did not know him before, as one of the representative gynecologists of London.

Dr. Smith has brought within a duodecimo of about two two hundred pages, as well as any one can, the chief practical knowledge of diseases of women. As a traveler, before visiting a new country, gets from a guide-book general directions as to his journey, and a sort of outline of the region he is to explore, so the student will find in this volume a hand-book to guide him in his studies. The physician, too, will find it useful for the revival of past knowledge—a sort of net to bring up from the sea of his memory forgotten facts and truths; and he will also realize its value in suggesting most of the new things that have sprung up in gynecological practice within the last few years.

Clinic of the Month.

THE FRACTURED FEMUR—DOES ITS LONGITUDE VARY WITH ITS LATITUDE?—This practical article, by Dr. Cowling, we extract from the Louisville Medical News of March 16th:

A number of lectures delivered by Prof. Frank Hamilton, during the winter past, on fractures of the long bones, have been published from time to time in several of our contemporaries. They must, of course, have attracted considerable attention as coming from one whose name is so intimately connected with the literature of fractures in this country. We wish we could think that the republication of his views would be productive of as general good. We use advisedly the word republication, for those who read Prof. Hamilton's last lectures must have been struck with the fact that in spite of slight symptoms he exhibited at one time of modifying the views of his earlier life, under the influence of changes made in the department of fractures, he returns wholly to his former opinions. Nay, more than that—as if to make amends for his apparent backsliding, he returns more deeply dyed than ever in the tenets of his ancient faith.

The peculiarities of Prof. Hamilton's ideas in regard to fractures may be stated to be the activity and multiplicity of the measures he deems necessary for their cure. We have neither space nor inclination to review here the details of his treatment of fractures in the several localities; but we do consider that the stand he has taken against the use of the plastic apparatus, in the treatment of fractures of the femur, ought not to pass unchallenged. Prof. Hamilton speaks with no uncertain sound against it. For two years he used it in alternate cases in practice, and he unqualifiedly condemns it. In his own hands, and in the hands of others, it was productive

of shortened and crooked limbs, excoriations, discomfort, and heart-breaking woes innumerable; and he is happy to state that its reign in New York is fast drawing to a close. If extension was tried by the perineum, says Prof. Hamilton, there was ulceration and slough; if the contour of the great muscle of the thigh was relied upon to give the necessary supports for this, the development of most thighs was not great enough to furnish the points; and in fractures of the femur in children, from the delicacy of their skin, the abundance of fat, the tendency to excoriation from the urine saturating the dressing, the short, fat limbs, and the restlessness of the subject, the acme of the difficulty is reached. Indeed, says Prof. Hamilton, the difficulty attending the treatment of these cases is so great that surgeons have generally dodged any separate consideration of it. "The books do not say much about it; for their authors have found it, no doubt, a very disagreeable subject, and most of them do not make any distinction between fracture of the femur in the child and in the adult." We may say, before leaving this part of the subject, that Prof. Hamilton still confines his patients with fractured femur in bed, with weight and pulley and splint and bandage for adults, and with the frame apparatus for children.

Now it sounds very strange to ears in this latitude to hear these last words from a great surgical center like New York. Of course, we would not think of putting individual experience against one who has the wards of such a great hospital at his command as has Prof. Hamilton; but surely the general experience in a city containing one hundred and forty thousand inhabitants, a long-established center of medical teaching, ought in thirteen years to have gathered something which can stand even against the greatest. It was about thirteen years ago that the plastic apparatus was first used in Louisville, to any very great extent at least, for fractures of the femur. We believe that it was principally by the example and teachings of Prof. D. W. Yandell that its use in this direction was spread hereabout. Starched apparatus had been previously used in fractures of the leg-bones, but the

long splint and perineal band were still in vogue with the thigh. Prof. Yandell had, with other surgeons in the Confederate army, witnessed its good effects in fractures of the femur, and commenced this practice of dressing such injuries in Louisville immediately after his return from the war. The first dressings used were the old cumbrous starched bandage, with paste-board splints to help stiffen them; usually requiring seventy-two hours to become dry. A few years later Mr. Tuffnell's admirable paste of flour and whites of eggs was substituted, and is used to this day in a number of cases, especially after union has taken place. In 1870 Dr. Cowling introduced manilla paper as a material to stiffen the apparatus. With the flour and eggs it dries in twelve hours or so, and makes one of the most beautiful of all models—smooth, light and durable. It is tedious to apply, however, and gave way, along with every other material, when, in 1871, the plaster-of-paris bandage came into use in Louisville. The plaster-of-paris bandage has not only held its own since that year in this city, but has steadily grown in the confidence of the profession, and its field of application has widened day by day. A long splint, a weight and pulley, an inclined plane, an anterior splint, a suspensory apparatus, are curiosities in this city. They were shown at the schools for a time among the appliances for treatment, exhibited later as vestiges of the past, but for five years they have slumbered undisturbed with the fathers.

The plastic apparatus is used for fractures of the foot-bones, of the leg-bones, of the patella and thigh-bone, in shaft and neck. (It constitutes, besides, the general treatment of joint-diseases, whether at ankle, knee, or hip.) It is put on as soon as it can be got on; it is disturbed as little as possible after it is on. Now with this general practice here, and with the practice of hundreds of practitioners in the South and West, who have carried away from the schools of Louisville abiding faith in the method, it strikes us it is about time for us to witness or to hear from a number of those fearful results recorded by Prof. Hamilton, if they follow in such numbers; and yet they do not appear. Of course perfect results are

not obtained in every single instance, but positively ill results are rare, and they can either be traced to the improper application of the apparatus or to causes which would have operated, no matter what treatment might have been substituted. A stiff joint in fracture through the joint, an excessively shortened leg in a compound and excessively oblique fracture, or a crooked limb when plain rules for the support of the upper fragment of the fractured bone have been neglected, has resulted in a very few instances; but where one man has limped after the use of the plastic apparatus a hundred have walked without doing so, and crushed and mangled limbs in numbers have not only escaped the knife, but have been almost perfectly restored. Have the limbs been shortened after thigh-fracture? Probably they have, as a rule, a half inch or so; bnt the gait does not show it, and most careful measurement has demonstrated, in some instances, that even in fracture of the upper third of the femur in adults positively no shortening has occurred.

Some one may ask, how is the necęssary extension kept up with the plastic apparatus? It is not kept up at all—that idea was exploded here half a dozen years ago, when the last extending band was laid aside. The bones being put in apposition, the plastic apparatus removes the causes which produce the shortening by its incomparable fixation somewhat, but probably most by the soothing influence of its equable warmth and gentle pressure, substituting, we imagine, persuasion for force. But the most curious thing about the use of the plastic apparatus in Louisville is, perhaps, that if it has any special field it is in the treatment of the fractured femur in children. On account of their tender skin, fat limbs, their tendency to irritation from discharges, their restlessness, etc., nothing so admirably suits them as the plaster-of-paris bandage. Absolutely free from pain after its application, causing often a doubt that fracture exists, playing with their toys in a few hours, easily handled and cleaned, out of bed in a day or so, crawling about, tumbling about, walking about on their crutches if they are old enough to walk at all, and coming out of the

bandages at the end of four or five weeks with sound and straight and unshortened limbs, with scarcely a redness thereon.

How are we to explain these widely different results in New York and Louisville? Is it not barely possible that we are not looking at the same shield at all—that the plastic apparatus of one place is not the plastic apparatus of the other? We do not know what method Prof. Hamilton used in his application of plaster-of-paris. We hope he did not—and in fact do not believe he did—put the bandage next to the skin. That were a stone coffin, indeed; and, if we remember rightly, he called it so. The method used here is not the Bavarian method, with the blanket and hinge. It may be a very good method; we know nothing about it practically, but it is not desired here; for when one of our surgeons puts up the limb he puts it up to stay up, in sublime faith of its coming out all right in the end, or else that it will give evidence by the discomfort it occasions that something is going wrong which must be remedied.

If Prof. Hamilton's dressers adjusted the fractured femurs early, under an anæsthetic; if they use smooth and ample layers of unbroken cotton-batting next to the limb, buttock, and back; if they were ordinarily skillful bandagers, and confined the cotton equably and with moderate firmness with dry rollers; if they carried a spica over the hip even for fracture just above the knee, and to make sure that they did carry the spica above the hip they brought it six inches above the crest of the ilium; if on the base thus constructed they placed two or three layers of plaster bandages made of slazy muslin (cheese-cloth) not longer than three yards each, into which dry plaster (best dental) had been thoroughly rubbed, and the bandages thus prepared were dipped into water and wetted through before application; if these bandages were smoothly applied, and especially thoroughly applied over the spica, which can be done without encircling the abdomen; if they removed any redundancy about the perineum so that the bandage might not touch it, and looked well to the cotton in

that locality, covering it with oil-silk if they cared to do so; if in the application of the plaster bandages the foot was kept rigidly at a right angle, and the knee straight or slightly flexed; if the case was looked to twice during the first twenty-four hours, and half a dozen times during the subsequent six weeks; then, if affairs turned as badly as Prof. Hamilton said, we must believe that the New York thigh and the Kentucky thigh have been evolved from different progenitors.

The fact is, we do not know what to think about the matter. We can hardly believe that Prof. Hamilton does not know how to apply the dressing, and it is hard to think that bone nature changes with latitudes, however strong our faith in the blue-grass beef and the bourbon. We are bothered, too, by conflicting statements in regard to the matter. Prof. Hamilton says his colleagues have pretty well abandoned the plastic dressings. He may think so, but one must go away from home to learn the news. Does not Prof. Van Buren still believe in it? is it possible that Dr. Sayre has weakened in his faith concerning it? and is its stout defender, Dr. St. John, ready to retract what he has said about it? We imagine Prof. Hamilton has been misinformed. Philadelphia would, of course, rather give up her machine-shops than the bewildering mechanism of her fracture wards, but New York is more progressive.

It would be foolish, of course, to declare that one method in the treatment of fractures gets all the good results, and other methods get all the bad ones. The fact is that under the best directed treatment by any method fracture-cases will sometimes result badly; and he who is swift to condemn a brother surgeon for this lacks as much in intelligence as he does in charity. The surgeon is most apt to get good results by the application of methods in which he has most facility. Early impressions are difficult to remove, and skill in new methods hard to acquire; hence it is that we deem it important that the plastic method of dressing fractures of the lower extremities should be thoroughly put before every student at the outset of his career.

We can not but think that the plastic dressings are among the greatest of the blessings of modern surgery, both to patient and to surgeon. They fill the whole measure of the law. They heal as quickly as the nature of the case will admit, as safely as by any method yet devised, and pleasant to a degree beyond the power of any other plan—past, present, and we may safely say future—to achieve. And if our words in their defense have been many, they are not wasted if they do but inspire one wavering brother to test their merits.

Terebene as a Dressing for Wounds.—Dr. T. G. Nasmyth, M. B., C. M., Edinburgh Medical Journal for March, gives this note as to the use of the above remedy:

The first case that I saw treated by this, was a gunshot wound of the hand, where several fingers were blown off and the hand much lacerated, and, from the nature of the injury, irregular and ragged flaps were left where the destroyed fingers had been removed. Terebene, in the proportion of one part to six of olive oil, was used from the first, there never was any putrefactive odor from the wound, very little sloughing took place, and the wound granulated kindly without any bad symptoms occurring. Its use was tested in another case, one of excision of hip-joint, where the acetabulum was diseased as well as the head of the femur. Terebene was applied on lint to the surface of the wound, and during the first day or two after the operation into the cavity of the wound; in this case there never was any bad odor either, and the large wound filled up very rapidly. Terebene seems to stimulate granulations more than carbolic applications. A wound of the scalp in a drunkard, who fell from a two-story house, healed without the slightest bad effect occurring, and in several other scalp wounds a like result followed. A case of gangrene, occurring in an amputation below the knee, and delirium tremens also complicating the case, tried terebene as a deodorizer thoroughly, and it answered satisfactorily. The smell from the gangrenous stump was kept down, the gangrene did not extend, and very little sloughing occurred. The patient recovered. As an ap-

plication to ulcers where there is a great amount of discharge, it is a good application, it diminishes the amount of discharge, and prevents the bad odor even in the most fetid ulcer. As an application to burns, it acts just as well as carron or carbolic oil, and it certainly is a more agreeable substance to use than the former. Although the number of cases in which I have seen it used is not very large, still they were cases which tried its value thorougly, and I have found it very useful. In cases where antiseptics can not be found—and these do occur especially in the country—terebene will be found a very useful application.

ENURESIS NOCTURNA.—Dr. Kelp, in speaking of this affection in the *Memorabilien*, February 20, 1878, says:

In this troublesome affliction, which generally occurs in young persons, but sometimes in the adult, but usually does not remain longer than through childhood, various remedies have been recommended and presented in practice. I have for a long time paid attention to the endermic use of nitrate of strychnia, and in some recent severe cases of enuresis obtained entire satisfaction. In one case I injected over the sacrum a solution of nitrate of strychnia, containing six centigrammes of the strychnia in seven and a half grammes of water, a half syringeful. In treating a case the injection is repeated so soon as the enuresis appears again. Usually it ceases after the *first* injection, but may appear again in a short time, until from repeated injections it entirely disappears. In December, 1877, I treated in this manner a young girl eighteen years old, who had suffered from scarlatina, who, since her long illness, for a month had suffered from nocturnal enuresis, which occurred every night, in spite of every precaution. Refraining from drinking during the evening, emptying of the bladder by getting up in the night, could not obviate the difficulty. However, after the administration of the first injection of the solution of strychnia, the enuresis ceased, but returned again after several days, but after repeating the hypodermic it has never, up to this time, reappeared. The patient is a strong healthy girl, and had, *before* her sickness, never suffered from enuresis.

Notes and Queries.

THREE ABLE COMMENCEMENT ADDRESSES.—We have been especially interested in three addresses recently delivered at medical college commencements. The first of these, the only one which we had the good fortune to hear, was by Dr. George Sutton, President of the Board of Trustees of the College of Physicians and Surgeons of Indiana. Dr. Sutton is one of the strong pillars of the profession in Indiana, a man who, in the midst of a laborious practice, has been not only a diligent medical student and an active member of medical societies, but has also found time to cultivate his love for general literature, and a study of some of those sciences more or less nearly related to medicine. His address was full of practical wisdom and judicious suggestions. We hope next month to publish it.

The other two addresses to which the title of this note refers, are by Professor William Goodell, of the University of Pennsylvania, and Professor J. M. Bodine, of the University of Louisville.

Dr. Goodell is one of the masters of English composition. His style is singularly terse, clear and strong, while his knowledge of ancient and modern literature, and his habits of close observation, furnish him with not only apt illustrations but brilliant ornaments.

The address is chiefly hortatory in character, and will prove of countless value to every young physician who heeds its wise advice.

From a writer so invariably chaste, accurate and elegant, we pause at "jaw-breaking" names, and stumble at "level best."

Dr. Goodell concludes his admirable address thus: "When the Breton sailor puts to sea, his prayer is, 'Keep me, my God, my boat is so small, and thy ocean is so big.'" Dr. Bodine enters into the heart of his subject with this passage: "The Breton mariner, when he puts to sea, prays, 'Keep me, my God, my boat is so small and the ocean so wide.'" We wonder how this pious Breton happened to sail into the field of vision of two gentlemen so far apart, at nearly the same time! Was he called into service in any other valedictory addresses? The story is so brief and so simple, and so striking, that we shall expect to hear it again.

Meantime Dr. Bodine has the right of priority in its use, his quotation having been made two weeks in advance of Dr. Goodell's.

Dr. Bodine's address has been beautifully printed and issued in pamphlet form by J. P. Morton & Co. Its subject is expressed in the question, "What am I?" and is an eloquent effort to maintain man's nobility in origin, in character, in destiny, as a living soul. It is a noble protest against the mere flesh and blood theory of human beings, and also makes a partial answer to that question which so often presents itself to the physician especially, Why is there suffering, physical pain, in this world? We congratulate our friend upon having prepared an address so able, interesting and useful.

A Stupid Reclamation.—We publish the following note, which is found in the Lancet, March 9th:

"Vomiting in Pregnancy.—*Sir:* I am somewhat surprised to see in your issue of to-day a paper by Dr. Jones, of Chicago, with an addendum by Dr. Marion Sims, in which the theory that the excessive vomiting occasionally attendant on pregnancy is due to uterine irritation is started as a novelty, and the suggestion made that it should be treated by the application of nitrate of silver to the cervix. It is, perhaps, not surprising that an American practitioner should be ignorant of the fact that the view was advocated many years ago by Henry Bennet, and the same treatment recommended. It is, however, astonishing that so accomplished a physi-

cian as Marion Sims should introduce so old a plan to the profession as a novelty discovered by his countryman. I turn to our latest systematic work on Midwifery, and find what I state amply corroborated. Permit me to make an extract in proof: 'Inasmuch as the vomiting unquestionably has its origin in the uterus, it is only natural that practitioners should endeavor to check it by remedies calculated to relieve the irritability of that organ. Dr. Henry Bennet directs especial attention to the condition of the cervix, which, he says, is almost always congested and inflamed, and covered with granular erosion. This he recommends to be treated by the application of nitrate of silver through the speculum. Dr. Clay, of Manchester, fully corroborates this view.' (Playfair's Science and Practice of Midwifery, vol. I., p. 212 and 213.) In justice to our fellow-countryman, Dr. Bennet, I trust you will insert this reclamation. I am, sir, yours, etc.,

"February 23, 1878. OBSTETRICUS."

"Obstetricus" is exceedingly charitable to American doctors—not surprising that they should be ignorant of Dr. Henry Bennet's views, etc. Really, the American profession hardly knew the views of any one else but Dr. Bennet, until the appearance of the admirable treatise of Dr. Thomas, upon diseases of women! The writer evidently does not know those views himself, for Dr. Bennet never advised the application of nitrate of silver to a healthy cervix, and in three of the cases reported by Dr. Jones, the cervix was healthy, while in the others the disease was trivial. The reclamation, therefore, of "Obstetricus," is, to say the least, very stupid.

AMATEUR VIVISECTION.—In reading that very interesting book, Reminiscences of Henry Crabb Robinson, we met the following curious statement as to Christian Brentano, a brother of one of Robinson's friends, who was managing the estates of his family in Bohemia: "To show that animals might be made to sustain the remedies which art has discovered for human miseries, he broke the legs of some cocks and hens, in order to make them walk with wooden legs." This Brentano, heathen we should call him rather than christian, ought to have been presented with a copy of Coleridge's Ancient Mariner.

"NEW METHOD OF EXTRACTING CATARACT"—INQUIRIES CONCERNING.—Dr. Thompson says, in his article on the above subject in the March number of the American Practitioner:

"No sooner had the knife entered the anterior chamber than the aqueous humor running beneath the conjunctiva pressed it out, so as to entirely obscure the upper margin of the cornea."

I. I can not understand how this would compel him to make his incision one-ninth of an inch from the upper margin of the cornea. I do not consider myself an expert, nor do I claim to operate better than Dr. Thompson, still I can not understand why only such an alternative was left him. I have had the accident occur a number of times, but it never prevented my making the incision where I intended to when I commenced.

II. "The knife, after the puncture and counter-puncture were completed, was turned upon its axis, and a straight incision was made." The knife is revolved while you are cutting out, I believe, still the incision is straight. I should think there would be considerable curvature to it—at least enough to prevent its being called a straight incision. Why is it called a straight incision?

III. "The iris is then drawn out by the operator," etc. In the cuts accompanying the article, and from the words used by the author in his description of his new method, one is led to believe that the iridectomy extends to the periphery, as in the Graefe and other operations. His cut shows it extending thus. How is it possible to do such a thing, when the incision is one-ninth of an inch from the margin of the cornea, unless the iris is torn loose from its attachments by traction, which most assuredly would be a dangerous undertaking, as the ciliary body, choroid, retina, and vitreous would be apt to come also? How, then, is this iridectomy performed? Or how does he remove the portion of the iris extending from his incision to the periphery, which is, according to Dr. Thompson, one-ninth of an inch in extent?

W. CHEATHAM, M. D.

ACRANIA.—Dr. W. T. Cleland, of Kewana, Ind., reports the following case of acrania:

Mrs. M. L., thirty-five years of age, between five and six months pregnant, consulted me on the twentieth of October. Fetal motions, which had been very distinct, were no longer recognized; the abdomen ceased to enlarge, she had nausea and constipation. Appropriate remedies being directed, she was soon better. Diagnosing death of the fetus, I advised her to wait until the normal period of pregnancy was accomplished, unless the condition of her health should demand interference.

On the twentieth of January I was again sent for, and found her with decided fever, furred tongue, severe pain in the stomach, bilious vomiting, and occasional uterine contractions. Giving her suitable remedies, I found her the next morning very much better, but decided expulsive pains had come on, by which the membranes had been ruptured. Upon digital examination, found the os uteri dilated to the size of a silver dollar, and a foot protruding. After dilating the os, in about thirty minutes the patient was delivered of the entire ovum. The fetus, which was in good preservation, presented very prominent eyes, an entire absence of brain, and only half an upper lip: the arms and legs were very long, and, as usually happens very fortunately in these cases, the body was small.

In a practice of over thirty years, I have met with many cases of similar fetal deformity. Young practitioners are often puzzled in recognizing the presenting part in such deformities. But whatever part may present, I think it always best to deliver by the feet.

LOUISIANA STATE MEDICAL ASSOCIATION.—This organization was effected in New Orleans last January. The following officers were elected: President, Dr. J. C. Egan; Vice-Presidents, Drs. S. M. Bemiss, J. W. Dupree and G. A. B. Hays; Recording Secretary, Dr. Thomas Layton, and Corresponding Secretary, Dr. S. S. Herrick; Dr. Geo. K. Pratt, Treasurer.

Dr. S. E. Chaillé was elected Orator for the first regular meeting.

Louisiana is late in organizing a State Society, but its eminent success is certain with such men as Bemiss, Richardson, Chaillé, Clay, Choppin, Holt, Jones, Herrick, Miles, Schuppert, and others, taking an active part.

A Forgotten Law.—In the minutes of the meeting of the American Medical Association at New Orleans, in 1869, we read that the following resolution was adopted: "That private handbills addressed to members of the medical profession, or by cards in medical journals, calling the attention of professional brethren to themselves as specialists, be declared in violation of the Code of Ethics of the American Medical Association."

It is time this law should be repealed, or else those who are violating it by advertising their specialties in medical journals —these violations are committed in Boston, Chicago, Nashville, and other cities—be required to withdraw their adver tisements.

Battey's Operation.—Dr. Sims has published in the British Medical Journal a very interesting paper upon this operation, and the paper has since been issued in pamphlet form. He is a warm advocate of the operation, though with his accustomed frankness he confesses but twenty-five per cent. of the patients operated on have been cured. He gives good reasons for the many failures, and points out the means of avoiding the mistakes that have been made in the operations that have failed.

The number of operations reported by Dr. Sims is twenty-eight, with five deaths. Now we happen to know of three others, the operator being in all respects able and competent, every one of which was fatal. Add these three to the twenty-eight given by Dr. Sims, and we have a total of thirty-one cases with eight deaths. Thus the operation resulted fatally in more than twenty-five per cent. Were all the cases of the operation collected, we would not be surprised to find the mortality greater.

AMPUTATION OF THE NECK OF THE UTERUS.—Dr. LeBlond, editor of the *Annales de Gynécologie*, has published an interesting memoir upon the above subject, it having first been presented to the Geneva International Medical Congress.

The monograph has numerous illustrations, and its conclusions are as follows:

I. Amputation of the neck of the uterus should be performed without traction upon the organ.

II. The galvano-caustic method is especially applicable in case of cancer, though it may also be employed in simple hypertrophy.

III. Not having the galvano-cautery, it is necessary to use the écraseur in cancer.

IV. Scissors are to be preferred to the bistoury when the galvano-cautery or écraseur is not used.

V. The bistoury should not be employed except in cases of hypertrophic elongation of the supra-vaginal neck.

A CURIOUS CASE.—A little child at Brighton has been killed by accidentally swallowing a squeaking air-bladder. It appears, from information kindly furnished us by Mr. G. A. Johnson, that the toy slipped through the glottis with the bladder downwards, and the quill mouthpiece upwards, so that with every inspiration the bladder became more or less inflated, and thus prevented the entrance of air to the lungs, and produced death by suffocation. A verdict of "accidentally suffocated" was returned by the jury. The case must be unique. (The Lancet.)

HOME FOR OPIUM HABITUÉS. — We invite attention in another column to the announcement of Parrish Hall, the Medical Home for Opium Habitués, Brooklyn, N. Y. It offers unusual facilities for the treatment of opium addiction, and we learn the results prove conclusively the efficacy of therapeutical resources in overcoming this formidable disorder.

A VERY DOUBTFUL EXTRA-UTERINE FETATION.—The Toledo Medical and Surgical Journal of March, contains a keen and needed criticism of a report recently made in the New York Medical Journal of a case given as "*Tubo-Interstitial Pregnancy—Destruction of the Life of the Fetus by the Galvanic Current.*" We think the profession generally will sustain the opinion of the critic, that it was a case of ordinary pregnancy, and that a needless abortion was produced.

DR. BELL'S EULOGY.—The eloquent address upon the life and services of the late Lunsford Pitts Yandell, published as a supplement to this number of the American Practitioner, we know will be read with great interest. Our subscribers have the advantage of this large number of extra pages without extra expense to them.

OVERCROWDING IN THE PROFESSION.—Not long since a medical gentlemen, advertising to dispose of a paying practice, received nearly two hundred applications, while another seeking for an opening was singularly neglected.—The Medical Record.